DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 01-010

2. STATE: South Carolina

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
August 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Medicaid Upper Payment Limit Requirements Effective March 13, 2001

7. FEDERAL BUDGET IMPACT:
a. FFY ~~2001~~ 2002 $ ~~116,296~~$9,045 *
b. FFY ~~2002~~ 2003 $ ~~116,440~~ $ ~~0~~ *

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Pages 1-4, 10, 21, 22, 29, 34-35; Pages 36-40 are submitted due to realignment.

Attachment 4.19-B, Pages 1 and 1a; Pages 1b-1d are submitted due to realignment.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Pages 1-4, 10, 21, 22, 29, 34-40

Attachment 4.19-B, Pages 1, 1a-1d

10. SUBJECT OF AMENDMENT:
Creation of 150% Medicaid Upper Limit Payment Pools for inpatient and outpatient services that will be paid to South Carolina non-state owned public hospitals.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

Virgil L. Chambers

12. SIGNATURE OF STATE AGENCY OFFICIAL:
William A. Prince

13. TYPED NAME:
William A. Prince

14. TITLE:
Director

15. DATE SUBMITTED:
July 30, 2001

16. RETURN TO:

South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
August 6, 2001

18. DATE APPROVED:
March 15, 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
August 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Rukena A. Grasser

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

* State Agency authorized "pen and ink" change to Federal Budget Impact.

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF SOUTH CAROLINA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL AND PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY CARE

I. General Provisions

A. Purpose

This plan establishes a prospective payment reimbursement system for inpatient hospital services and inpatient psychiatric residential treatment services in accordance with the Code of Federal Regulations. It describes principles to be followed by Title XIX inpatient hospital and psychiatric residential treatment providers and presents the necessary procedures for setting rates, making adjustments, auditing cost reports and managing the hospital disproportionate share program.

B. Objectives

Pursuant to the requirements of the Omnibus Budget Reconciliation Act (OBRA) of 1981 that provider reimbursements be reasonable and adequate to assure an efficient and economically operated facility, the prospective rate plan herein described will apply.

Effective October 1, 1997, the Balanced Budget Act (BBA) of 1997 repeals the OBRA 1981 requirement stated above. In its place, the BBA of 1997 provides for a public process for determination of hospital payment rates. This public process will take place for all changes in payment for inpatient hospital and psychiatric residential treatment facility services and disproportionate share.

C. Overview of Reimbursement Principles

1. Effective January 1, 1986, the South Carolina Medicaid Program will reimburse qualified providers for inpatient institutional services based on the prospective payment rates developed for each facility as determined in accordance with this plan. In addition, effective August 1, 2001, South Carolina non-state owned public facilities will be eligible to receive lump sum payments from a pool of funds (the 150% Upper Payment Limit (UPL) Pool). Payments to each facility will be made in accordance with the UPL regulations 42 CFR 447.271 and 447.272.

2. Medicaid reimbursement to a hospital shall be payment in full. Hospitals may not separately bill the patient or the Medicaid program for medical services rendered during an inpatient stay, except as provided in Section III of this plan. Hospitals may submit a claim for payment only upon final discharge of the patient, with the exception of long-term care psychiatric hospital claims and psychiatric residential treatment facility claims.

3. All inpatient services associated with admissions occurring on or after January 1, 1987, furnished by hospitals, are subject to the Hybrid prospective payment system. Special prospective payment system provisions are included for services provided by freestanding long-term care psychiatric hospitals.

4. Payment for all hospitals except those identified in 3 above will be made based on a Hybrid system which compensates hospitals either an amount per discharge (per case) for a diagnosis related group or a prospective per diem rate. DRG categories that are frequent, relatively homogeneous and considered by clinical experts not to be of a highly specialized nature will be paid an amount per discharge for each DRG category. DRG categories that are infrequent, highly variant and/or are considered by clinical experts to be of a highly specialized nature will be paid a hospital-specific per diem rate appropriate for the type of service rendered.

5. For discharges paid by the per case method under the Hybrid System, South Carolina specific relative weights and rates will be utilized. The DRG classification system to be used will be the classification system currently used by the Medicare program. The relative weights will be established based on a comparison of charges for each DRG category to charges for all categories. South Carolina's historical Medicaid claims database will be used to establish the DRG relative weights.

6. For discharges paid by the per diem method, an appropriate hospital-specific per diem rate will be established for the type of service. The per diem rate will distinguish routine, special care, and neonatal intensive care days and will further distinguish these into surgery and non-surgery cases. Facilities will receive the appropriate per diem rate times the number of days of stay, subject to the limits defined in this plan.

7. An outlier set-aside adjustment (to cover outlier payments described in 10 of this section) will be made to the per discharge rates.

8. Payment for services provided in freestanding long-term care psychiatric facilities shall be based on the statewide average per diem for psychiatric long-term care. The base per diem rate will be the statewide total costs of these psychiatric services divided by total psychiatric days.

9. The prospective payments determined under both payment methods, the Hybrid prospective payment system for general acute care hospitals,

distinct part units and short term care psychiatric hospitals and the per diem method for psychiatric long-term care facilities will be adjusted to recognize facility specific costs associated with direct and indirect medical education, capital and ancillary services as appropriate. Capital and direct medical education will be reimbursed prospectively on an interim basis, and retrospectively settled at a future date. Disproportionate share hospitals will not be eligible for cost settlements in accordance with the upper payment limit requirements of the OBRA 1993. Effective October 1, 1999, South Carolina Department of Mental Health hospitals will be reimbursed 100% of their allowable Medicaid inpatient cost through a retrospective cost settlement process.

10. Special payment provisions, as provided in Section VI A of this plan, will be available under the Hybrid prospective payment system for discharges paid by DRG which are atypical in terms of patient length of stay or costs of services provided during the stay. These cases will be referred to as outliers. Special payment policies, as specified in Section VI C and D of this plan, will also be made for cases involving a transfer of a patient from one hospital to another, or a readmission of a patient following an earlier discharge. These provisions are not applicable to long-term psychiatric and RTF claims.

11. Reduced payment, as specified in Section VI B of this plan, will be made for cases paid on a per diem basis having stays exceeding two hundred percent of the hospital specific average length of stay.

12. A rate reconsideration process will be available to hospitals which have higher costs as a result of conditions described in IX B of this plan.

13. Disproportionate share payments will be paid to qualifying hospitals in accordance with the requirements specified in Section VII of this plan.

14. Payment for services provided in psychiatric residential treatment facilities shall be an all-inclusive per diem rate. Section II paragraph 29 of this plan defines the costs covered by the all-inclusive rate. Each facility's per diem rate will be calculated using base year data trended forward. Section V B describes the rate calculation.

15. Effective October 1, 1998, reimbursement for statewide pediatric telephone triage services will be available for the designated South Carolina Children's Hospitals. Payment will be based on the Medicaid portion of allowable service cost.

16. Effective October 1, 1999, a small hospital access payment will be paid to qualifying hospitals that provide access to care for Medicaid clients.

17. Effective Effective October 1, 1999, a high volume Medicaid adjuster payment will be paid to hospitals that serve a significantly high volume of Medicaid patients.

18. Effective October 1, 2000, hospitals participating in the SC Universal Newborn Hearing Screening, Detection, and Early Intervention Program will be reimbursed for Medicaid newborn hearing screenings. Effective July 1, 2001, all hospitals will be eligible for this reimbursement.

19. Effective August 1, 2001, South Carolina non-state owned public hospitals will be eligible for a lump sum payment from a newly created Upper Payment Limit pool. Payment will be made as described in Section VIII of this plan.

licensed and certified as a hospital. This service will include both scheduled services and the provision of service on an emergency basis in an area meeting licensing and certification criteria.

26. Pediatric Telephone Triage Services - Services provided by qualified medical personnel to assist callers in determining the nature of a child's medical problem and the appropriate action to take (e.g. see a physician the next day, go immediately to an emergency room, etc.). This service is available for parents or caretakers of SC Medicaid children 0 through 18 years old.

27. Principal Diagnosis - The diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital.

28. Psychiatric Distinct Part - A unit where psychiatric services are provided within a licensed and certified hospital. Patients in these units will be reimbursed through the Hybrid PPS.

29. Psychiatric Residential Treatment Facility - An institution primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons who require less than hospital services. Medicare certification is not required. Effective April 1, 1994 in-state psychiatric residential treatment facilities are required to be licensed by DHEC in order to receive Medicaid reimbursement as described in State Plan Attachment 3.1-C, page 9.

Residential Treatment Facilities are neither acute care nor long-term care facilities. A Psychiatric Residential Treatment Facility is a facility that is accredited by the Joint Commission of Accreditation of Health Care Organizations (JCAHO), operated for the primary purpose of providing active treatment services for mental illness in a non-hospital based residential setting to persons under 21 years of age. Facilities must meet the federal regulations for inpatient psychiatric services at 42 CFR 440.160 and Subpart D for Part 441. Length of stay in a Psychiatric Residential Treatment Facility may range from one (1) month to more than twelve (12) months depending upon the individual's psychiatric condition as reviewed every 30 days by a physician.

30. Residential Treatment Facility All-Inclusive Rate - The all-inclusive rate will provide reimbursement for all treatment related to the psychiatric stay, psychiatric professional fees, and all drugs prescribed and dispensed to a client while residing in the Residential Treatment Facility.

31. Short Term Care Psychiatric Hospital - A licensed, certified hospital providing psychiatric services to patients with average lengths of stay of twenty-five (25) days or less. Patients in these hospitals will be reimbursed through the Hybrid PPS.

32. Small Hospital Access Payment - A payment for Medicaid participating

to-midpoint inflation rates are as follows:

FY 2000	6.37%
FY 2001	10.22%

Because audited cost reports are not available for the base year, desk audited cost report data will be used to set an interim rate. This interim rate will be effective until audited data is available. After an audit is performed, the interim rate may be adjusted to reflect audited allowable cost. If the rate is revised, all payments calculated with the interim rate will be adjusted to reflect payment with the final rate. See section X C 4 for retrospective cost settlement requirements.

V. Reimbursement Rates

A. Inpatient Hospital

The computation of prospective rates under the Hybrid plan will require three distinct methods - one for computation of per discharge rates under the Hybrid PPS and a second for computation of per diem rates under the Hybrid PPS and a third for computation of the statewide per diem rate for freestanding long-term care psychiatric facilities.

1. Per Discharge Prospective Payment Rates

The following are involved in the computation of per discharge reimbursement rates.

a. A statewide average cost per discharge is computed by summing the total adjusted inpatient Medicaid cost allocated to the per case DRGs for all facilities and dividing by the sum of the per case Medicaid discharges for all facilities. The inpatient Medicaid cost used in this equation will be adjusted as described in Section IV as noted below.

B.3.a - direct medical education (if applicable)
B.3.b - capital
B.5 - malpractice
H - case-mix
C.1 - indirect medical education
D - inflation
J - outlier set-aside (.08472)

b. Hospital-specific add-ons as derived in Section IV C will then be added to the rate using the following general methodology.

(1) Medicaid's share of inpatient capital and capital related costs allocated to per case DRGs will be case-mix adjusted and divided by the Medicaid per case discharges to yield the capital add-on to be added to the base rate.

(2) Medicaid's share of direct medical education cost allocated to per case DRGs will be case-mix adjusted and inflated and then divided by the Medicaid per case discharges to yield the direct medical education add-on to be added to the base rates.

(3) Medicaid's share of indirect medical education costs allocated to per case DRGs will be inflated and then divided by the Medicaid per case discharges to yield the indirect medical education add-on to be added to the base rate.

(4) Rate reconsideration adjustments granted under Section IX B that consist of percent or fixed additions to the base

F. Payment for Swing Bed Days

Acute care facilities will be reimbursed for qualifying skilled and intermediate care Medicaid patients in accordance with the daily rate schedule shown below.

October 1, 1992 - September 30, 1993	$62.67
October 1, 1993 - September 30, 1994	67.22
October 1, 1994 - September 30, 1995	70.36
October 1, 1995 - September 30, 1996	75.84
October 1, 1996 - September 30, 1997	79.01
October 1, 1997 - September 30, 1998	83.38
October 1, 1998 - September 30, 1999	86.69
October 1, 1999 - September 30, 2000	92.64
October 1, 2000 -	96.85

This rate calculation is described in the Nursing Home State Plan Attachment 4.19 D, page 35, paragraph I.

G. Payment for Administrative Days

Acute care facilities will be reimbursed for Medicaid eligible skilled or intermediate patients who no longer require acute care and are waiting for nursing home placement. Administrative days must follow an acute inpatient hospital stay and will be covered in any hospital as long as a nursing home bed is not available. Reimbursement for administrative days is described below.

1. Each administrative day will be paid in accordance with the rate schedule shown below. This daily rate will be considered payment in full. There will be no cost settlement. This rate is a combination of the swing bed rate, as defined above, plus the Alternative Reimbursement Method (ARM) rate for pharmaceutical services.

October 1, 1994 - September 30, 1995	$73.98 (ARM $3.62)
October 1, 1995 - September 30, 1996	79.68 (ARM 3.84)
October 1, 1996 - September 30, 1997	83.23 (ARM 4.22)
October 1, 1997 - September 30, 1998	88.02 (ARM 4.64)
October 1, 1998 - September 30, 1999	91.79 (ARM 5.10)
October 1, 1999 - September 30, 2000	98.21 (ARM 5.57)
October 1, 2000 -	103.85 (ARM 7.00)

2. A rate of $180.00 per day will be available for administrative day patients who require more intensive technical services (i.e. patients who have extreme medical conditions which require total dependence on a life support system). This rate was determined by cost analysis of:

   a. A small rural S. C. hospital which was targeted to set up a ward to provide services for this level of care and

   b. An out-of-state provider that has established a wing in a nursing facility to deliver this type of service.

VIII. Upper Payment Limit (UPL)

In accordance with the Revision to the Medicaid UPL Requirements, effective March 13, 2001, state Medicaid programs are allowed to reimburse non-state owned public hospitals at 150% of their allowable Medicaid reimbursable cost for both inpatient and outpatient services. Separate aggregate UPLs are established for both inpatient and outpatient services. The following methodology describes the method to be employed by the SCDHHS in determining the non-DSH South Carolina non-state owned public hospital lump sum payments as it relates to inpatient services. The non-DSH South Carolina non-state owned public hospital lump sum payment methodology relating to outpatient services is described in Attachment 4.19-B section 2.a.I.A.

A. 150% UPL Pool

The following methodology will be used to determine the pool of funds available under the non-state owned public hospital inpatient UPL:

1. The FY 1998 cost report period will be used as the base year in the determination of the 150% inpatient UPL for non-state owned public hospitals.

2. The FY 1998 Medicaid inpatient charges will be multiplied by each non-state owned public hospital's FY 1998 inpatient cost-to-charge ratio. This will establish each hospital's FY 1998 inpatient cost. Additionally, FY 1998 Medicaid inpatient trauma costs for Level I trauma hospitals (as defined under Section VII A(2)) will also be included. In order to trend the FY 1998 cost forward to FFY 2001, the SCDHHS shall employ the mid-point to mid-point inflation method using the following HCFA inflation factors:

2.80%	CY 1998
2.40%	CY 1999
3.90%	CY 2000
3.30%	CY 2001

3. Each non-state owned public hospital's Medicaid inpatient revenue will be determined through the end of FFY 2001 based on actual FY 1998 Medicaid inpatient revenue, plus projected Medicaid inpatient revenue received through September 30, 2001. Projected Medicaid inpatient revenue will include any base rate increases since FY 1998, plus applicable small hospital access payments and high volume adjustment payments.

4. Each non-state owned public hospital's unreimbursed Medicaid inpatient cost at 150% will be determined by subtracting the projected FFY 2001 Medicaid inpatient revenue, as defined in 3 above, from trended FFY 2001 Medicaid inpatient cost at 150%, as defined in 2 above. Both in state and out of state non-state owned public hospitals' unreimbursed Medicaid inpatient cost at 150% will be summed to determine the aggregate payment that can be made. This will represent the maximum additional lump sum payment that the SCDHHS can make under the new Medicaid UPL regulations.

B. Payments

Effective August 1, 2001, the SCDHHS will make lump sum payments from the 150% I/P UPL pool to all non-DSH South Carolina non-state owned